

HEALTH REFORM AND ITS IMPLICATIONS

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ABSTRACT

This paper discusses the various types of health reforms, its objectives and principles. Illustrations and examples of health reforms were given namely drug financing health reform, reform in maternal and child health services and health reforms in South Africa, Zambia and Malaysia. Issues in health reforms were also discussed.

INTRODUCTION

What is Health Reform? Health reform means building on the strength of the current health system and rectifying the weaknesses to achieve public health goods¹. Reforms to a better performance of the health system will ultimately increase the possibilities of health security and prosperity of a nation. Health reform is also a complex process and it requires the courage of the government leadership, the cooperation and dedicated efforts of the public and private personnel, and the participation of the people.

The guiding principles to any health reform program should consider the following aspects:-

- **Universality:** covering the whole population with a basic package of priority services where everyone in the country has the same access and benefits from the basic health care provided.
- **Quality:** improving and ensuring the standards of care and health facilities, enhancing diagnostic and clinical effectiveness, updating medical education and training with focus on professionalism, ethical issues, patient satisfaction and trust with updated medical technologies.
- **Equity:** financing for health services is usually based on ability to pay, while provision of services is based on needs, thus there should be an efficient funding scheme which benefits all members of the community.
- **Efficiency:** allocation and mobilization of human, financial and infrastructure resources for health based on population needs and cost-effectiveness.
- **Sustainability:** ensuring continuity, self sufficiency and lasting establishment of the health system reforms and services for the health and well-being for the present and the future.

Many European countries have been or are presently going through a process of reform of the health care sector. The impetus for such reforms comes from the inability to control costs, criticism of bureaucratic rigidity, and the impression of getting

poor value for money (Dekker 1994). Most attention goes to the supply side, and the reform debate is dominated by a focus on administrative/financial and organizational issues (Oevretveit 1994). There is a characteristic shift towards market-derived incentives in pursuit of micro-economic efficiency and control of expenditure (Saltman 1994).

Developing countries are increasingly interested in following similar approaches in order to control costs, and to correct obvious government failures in financing and provision of health care (World Bank 1993). As in Europe, reliance on the private sector and managed markets is supposed to enhance provider efficiency through competition and substitution of direct management with contractual relationship.

A growing number of developing countries are now embarking on reforms in which contracting out clinical services – and specifically hospital care – is the key element. The speed with which these approaches have been endorsed in development circles is in sharp contrast with the lack of actual experience and empirical evidence for success (Carr-Hill 1994). Appropriate regulation technologies and capacities need to be developed. Reforming the health care sector in developing countries is indeed subject to specific constraints that center around the government's regulatory capacity and the strength of its bargaining position (McPake & Hongoro 1995).

From the above discussion, it is noted that some of the reasons for health reform are as follows:-

- Inability to control cost
- Crisis in financing health sector
- Criticism of bureaucratic rigidity
- Impression of getting poor value for money
- Governments failure to deliver health care

OBJECTIVES AND PRINCIPLES OF HEALTH REFORM

Health reform in its aim to improve the delivery of health services to the population have the following objectives and principles.

- **Equity;** which comprises ensuring access to essential health services to the portions of the population at financial and geographical disadvantage

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- *Quality*; which incorporates the effectiveness of treatment and consumer satisfaction with health services provided
- Efficiency*; which includes:-
 - *Allocative efficiency* – distribution of resources across services so as to maximize health benefits
 - *Administrative efficiency* – management structure of health are designed to promote most efficiency use of resources
 - *Technical efficiency* – services are provided at the lowest possible cost

COMPONENTS OF HEALTH REFORMS

The major components of the health reform involves the following:-

- a. Improving the performance of civil services (reducing staff numbers, changing pay, grading and appraisal system, and reworking job description).
- b. Decentralization (management systems/health care provision devolved to local government or other agencies closed to local populations)
- c. Improving the functioning of national ministries of health (organizational restructuring to improve human and financial resources management, monitoring performance, defining priorities and cost effectiveness interventions)
- d. Broadening health financing options (introducing of user fees, community funding mechanism, social and private insurance mechanism, voucher system)
- e. Introducing managed competition (promoting competition between health service providers/multiple purchasers)

- f. Working with the private sector (establishing systems for regulating, contracting with, or franchising providers in the private sector)

TYPES OF HEALTH REFORM AND EXAMPLES

Generally there are two main types of health reforms:-

- **Financing Reform**
 - Public drug expenditure
 - Health insurance
 - User charge
 - Voluntary and other local financing
 - Donor financing and drug donation
 - Development loans
- **Organizational reform**
 - Primary care strategy
 - Restructuring of services
 - Training of health personnel

Examples of some of the types of health reforms will be discussed below.

Health reform in drug financing

Using pharmaceutical expenditures as an example, pharmaceutical expenditures as well as overall health expenditures, are linked to economic development (they tend to increase as GDP increases). However, pharmaceutical consumption as a percentage of GDP shows much less variation among regions than does overall health expenditure (Table 1).

Furthermore, in lower income countries, pharmaceuticals generally account for a more significant share of overall health expenditures than in established market economies (for which this share is about 15%). For example, in countries such as China, Indonesia, and Thailand, this share ranges from 35-45% [46]. In several African countries, it is believed to exceed 50%.

Table 1: Health and pharmaceutical expenditures by region, 1990 *

Region	Health expenditures		Health expenditures by source (% of total)			Total pharmaceutical expenditures		Private as % of total pharmaceutical expenditures
	Total per capita (US\$)	% GDP	Public	Private	Aid	Per capita (US\$)	% GDP	
Sub-Saharan Africa	36	4.9	33.4	37.6	29.5	8	.9	65
Asia	60	4.0	40.9	48.1	11.0	12	.6	81
Middle Eastern Crescent	190	4.3	55.0	42.9	3.6	27	.7	74
Latin America	118	5.3	54.9	37.4	7.6	26	.9	72
Transitional economies	150	4.3	72.7	27.3	0.0	--	--	--
Established market economies	1675	7.7	77.0	23.0	0.0	138	.6	40

* Source: WHO/DAP (1998). *Health reform and drug financing: Selected topics*

In developing regions, 50 to 90% of the overall pharmaceutical expenditures are privately financed, which is considerably higher than in industrialized countries (median is 34%) (WHO/DAP 1997).

Because drugs account for such a large portion of health expenditures, and because the purchase of these products often requires spending in foreign currency, inefficiencies in drug production, procurement, storage, distribution, and use can be a significant element of waste within the health sector.

Drug financing reforms, efforts to promote affordability and efficiency, and organizational reforms are critical elements in the overall health sector reform process. Drug financing reforms involves three main aspects namely financing reform, affordability and efficiency, and organizational reforms.

Drug financing reforms

Health reform in drug financing focuses on the perspective of certain financial aspects of health - public financing, health insurance, user charges, donor financing and drug donations, and development loans.

Public financing : Some public spending will always be needed to ensure access to drugs by the poorest in society; to ensure provision of drugs for tuberculosis, sexually transmitted diseases, and other communicable diseases; and to ensure care for target groups such as mothers and children. As a share of

national economic output (GNP), public spending on health in developing countries is one-quarter to one-half that of industrialized countries. Health financing reform should improve the use of public resources, but it should not be aimed to further reduce public spending on health.

The level of public commitment for financing health care and drugs should be a matter of explicit public policy, based on an analysis of health care needs and financing options. Policy makers, managers responsible for health care financing, and essential drugs managers should be familiar with the methods for analyzing public financing of drugs and for planning public expenditures for drugs.

Examples of the public drug financing are observed in Bhutan and Indonesia as illustrated in Figure 1.

What determines public spending on health and drugs? In practice, actual per capita expenditures are determined by a combination of factors including: political will; national economic output (GNP); the share of GNP collected in taxes as government revenue; the share of government spending devoted to health; the existence of publicly managed health insurance coverage; the share of health spending devoted to recurrent operating costs versus capital development costs; and the share of health spending devoted to pharmaceuticals. Figure 2 illustrates several of these factors for two low-income countries, one with a high commitment to health and essential drugs spending and one with low commitment.

Bhutan

- It is unusual for a developing country in that it provides most of its drugs (90%) through the public sector.
- Public drug expenditure is roughly US\$1 per capita annually, 70% of which is covered directly by the central government allocations (=63% of total pharmaceutical spending) and the remaining 30% is covered by multilateral and bilateral donors.
- An essential drugs list exists (326 dosage forms categorized by levels of use in 1995) and is used in the purchase of drugs through international tenders.

Indonesia

- The public sector contributes one-quarter of the US\$ 3.75 per capita which is spent annually for pharmaceuticals by both public and private sources. Of this public contribution, two-thirds comes from central government allocations (=16.7% of total pharmaceutical spending), with the remaining contributions coming from civil servant health insurance schemes, provincial and district budgets, and donors' vertical programs.
- The central allocation for drugs is determined each year on a per capita basis (US\$ 0.50 in 1990) using official population figures which set provincial and district budgets.

Districts place their orders for drugs after being notified, according to a schedule, of their budgets, and of prices for drugs on the national essential drugs list. Drugs are delivered to district warehouses by both public and private supply channels.

Source: WHO/DAP (1998). *Health reform and drug financing: Selected topics*

Figure 1 : Role of public drug expenditures in Bhutan and Indonesia

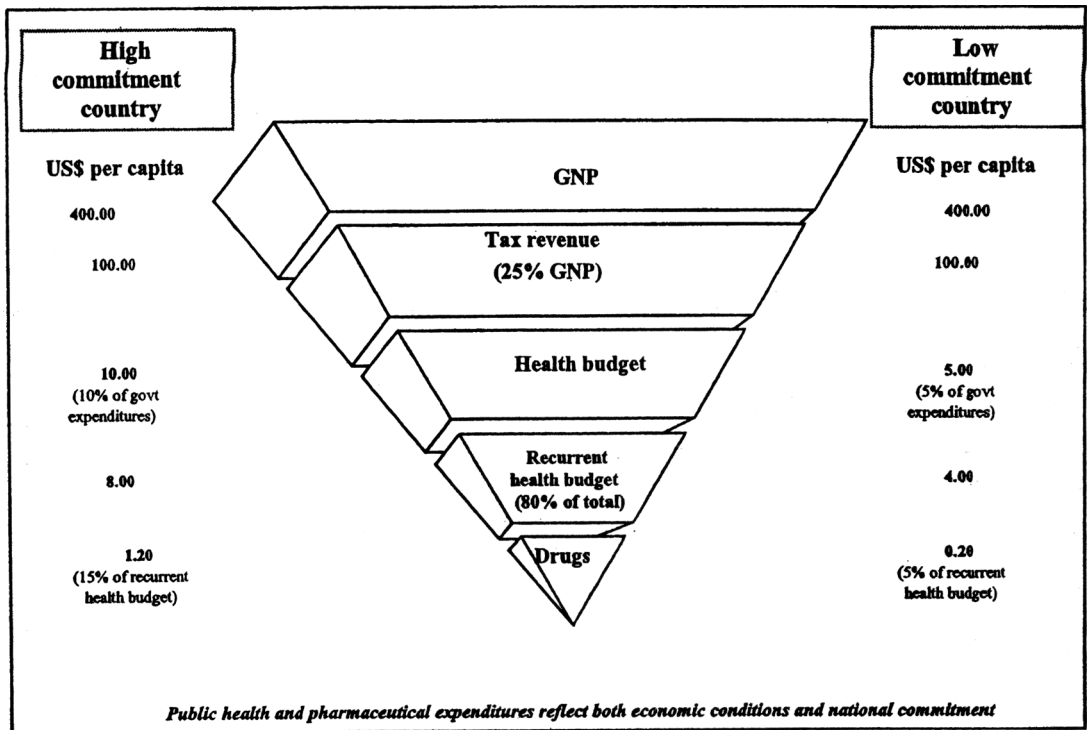


Figure 2: Public pharmaceutical expenditures in low and high commitment countries

Table 2. Total government expenditures and health expenditures*

	Total government expenditures as % GNP (median)	Health as % of total government expenditures (median)	Public health expenditures as % GNP (mean)
Established market economies	42.5	12.5	5.9
Middle Eastern Crescent	33.2	4.3	2.6
Transitional economies	55.6	4.8	3.2
Latin America and Caribbean	17.1	6.7	2.9
Asia and Islands*	19.9	4.7	1.7
Sub-Saharan Africa	29.7	7.0	1.6
India	17.5	1.6	1.2
China	---	---	2.1

* Source: WHO/DAP (1998). *Health reform and drug financing: Selected topics*

Actual regional differences in levels of total government expenditures and public support for health are shown in Table 2. In the established market economies and transitional economies, central government expenditures total over 40% of GNP, while the median for government expenditures in other regions is roughly 20% to 30% of GNP. Health generally receives less than half the share of government expenditures in developing countries (1.6% to 7%) than it does in the established market economies (12.5%).

How do differences in health and drug financing appear at the national level? Data on total public health and drug expenditures for 11 countries are shown in Table 3. Total public health

expenditures are consistent with regional figures listed above, but vary greatly among countries. But within the health sector, the share of budget devoted to drugs also varies - from 4.5% in Chad and 5.6% in Thailand, to 20.0% in Vietnam and 36.1% in Zimbabwe.

The combined effects of lower national output, government spending as a share of GNP, and decisions about public spending on health and drugs, is that per capita drug expenditures vary greatly among the 11 countries. Governments in Chad, Guinea, India (Andhra Pradesh), Mali, and Vietnam all spend less than \$0.50 per capita on drugs. Sri Lanka, a poor country, still manages to spend US\$1.34 on drugs.

Table 3. Public health and drug expenditures for selected countries

	Total public health expenditures		Total public drug expenditures	
	As % GNP	Per capita (US\$)	As % health budget	Per capita (US\$)
Bulgaria	3.9%	44.76	18.4%	8.24
Zimbabwe	2.8%	12.43	36.1%	4.49
Colombia	1.5%	20.03	18.0%	3.61
Thailand	2.0%	33.65	5.6%	1.89
Sri Lanka	1.5%	8.58	15.6%	1.34
Philippines	0.5%	4.53	13.3%	0.60
Vietnam	1.1%	2.32	20.0%	0.46
Guinea	0.4%	1.73	15.8%	0.27
Mali	0.4%	0.74	18.8%	0.14
India (Andhra Pradesh)	3.2%	1.93	6.8%	0.13
Chad	0.6%	1.06	4.5%	0.05

Source: Based on data presented in WHO/DAP. (1996). Informal consultation on evolving public-private roles in the pharmaceutical sector. Data are from the most recent year available, generally early 1990s.

WHO has previously suggested a minimum figure of US\$ 1.00 per capita annually as an appropriate target for public expenditures for drugs (WHO/DAP 1997). However, the adequacy of this figure depends on several factors, including the volume of government-financed health care, the range of conditions for which drugs are provided, and the availability of other financing sources such as insurance and user fees.

Health insurance : Formal health insurance and various informal community insurance programs represent a growing source of health and drug financing in transitional and developing countries. The experience of many countries has shown that compulsory social insurance can be the critical step to a more equitable health care system. It must be recognized, however, that some developing countries will have difficulties in implementing widespread insurance coverage in the short-term for a number of reasons including limited formal employment and weak state mechanisms.

There are benefits in providing pharmaceutical coverage together with health coverage although challenges, such as difficulties in tracking prescriptions, exist. Policy makers and managers need to be fully informed about the value of insurance coverage, alternative mechanisms for providing pharmaceutical benefits, and methods to ensure quality of care, while controlling costs.

Universal health insurance is a feature of almost all the health systems of developed market economies (a notable exception is the United States of America) and appears to improve affordability, while promoting equity and solidarity in these systems. In most developing countries, the situation is quite different. The region with the lowest insurance coverage (mean) is Sub-Saharan Africa, 10.3%; this is followed by Asia (excluding China and India), 27.3%; Latin America, 45%; and the Middle East Crescent, 56.7% (see Table 4).

Not all insurance mechanisms - be they public or private - will cover the costs of drugs. However, several arguments can be made for including drugs. First, drugs are an essential and highly cost-effective part of modern health care. Second, drugs make up a large share of household expenses and their inclusion in either a compulsory or a voluntary insurance scheme will make the scheme more acceptable. Finally, effective early treatment of acute illnesses, such as malaria and pneumonia, and routine treatment of chronic illnesses, such as diabetes, not only improves health, but also reduces costly care for complications and hospitalizations. As illustrated in Figure 3, there are both benefits and difficulties associated with various insurance mechanisms.

User charges : User charges are increasingly being implemented by governments and local communities in countries at all levels of development, both to supplement general government revenues or insurance premiums, and to help control utilization. Often, however, such programs have not learned from past experiences, are not well managed, and, as a result, access shows no improvement, revenue replaces rather than supplements government funding, and drugs are over prescribed.

User fees can complement government allocations for pharmaceuticals, but should not replace them. Future efforts need to ensure that the lessons from existing research and actual experience are applied to the design, implementation and monitoring of user fee programs to ensure that access to drugs does improve and that rational use does not suffer. When fee mechanisms are instituted at a national level, a top-down approach, starting with major national and local hospitals, may have advantages in terms of equity, reinforcement of the referral system, revenue potential, administrative capacity, and impact evaluation.

Table 4: Distribution of health insurance coverage by region

Regions/countries	Population coverage for countries with insurance			Country distribution of insurance coverage	
	Mean	Median	Range	With insurance	Not known or no insurance*
Established market economies	98.7	100.0	86 – 100	13	12
Middle Eastern Crescent	56.7	50.0	15 – 100	7	25
Latin America and Caribbean	45.0	35.5	6 – 100	20	13
Asia and Islands*	27.3	10.2	1 – 100	12	19
Sub-Saharan Africa	10.3	8.0	1 – 26.5	14	33
India		5.0			
China		30.0			

For the transitional economies, 7 countries have no available data, 11 countries have less than 1% insurance coverage and the Czech Republic has 100% coverage.

* Coverage is less than 1%

* Except China and India

Source: Creese A L, Kutzin J. (1995). *Lessons from cost-recovery in health. Forum on health sector reform. Discussion paper No. 2. Geneva: World Health Organization*

Social insurance

- **Costa Rica:** The Costa Rican Social Security Fund, CCSS, now provides nearly universal health insurance coverage to the population. Funds are derived from a variety of sources including employers, employees, the self-employed, and a contribution from the central government. CCSS covers about 80% of health expenditures and includes in this both curative and preventive care. Drug availability at CCSS pharmacies is high and drugs are provided free of charge with no co-payments. They are prescribed and dispensed according to generic name, and are almost always those found in the CCSS formulary (535 drugs and dosage forms)(MSH/WHO/DAP 1997, Normand & Weber 1994)
- **Thailand:** Roughly 72% of the Thai population receives health coverage through some form of insurance. Both social welfare and social security (providing coverage for 56% of the population) require the use of essential drugs, while coverage for civil servants and voluntary private insurance do not. About 67% of health expenditures are financed privately because patients prefer self-medication and treatment at private clinics, which public insurance does not cover (WHO/DAP 1996). A separate insurance system - a voluntary health card scheme - was created to insure those in rural areas for the fees associated with services provided by the public sector (WHO 1994). Use of essential drugs is mandatory with this public health card [42]. The effectiveness of this form of insurance has yet to be evaluated.

Community-based insurance

- **Guinea-Bissau:** Pre-payment schemes have been developed in rural communities with community-managed village health posts as a means of ensuring health care and drug provision during the half of the year in which no monetary economy exists. Villages decide both the rates and the methods of pre-payment. For those individuals who contribute, drugs and services are free of charge at the time of provision. Participation is, on average, over 90% of those eligible. Although there were issues with drug restocking due to constraints at the central medical store, drugs had become more available in two-thirds of the villages and, where this was not the case, villagers still perceived the quality of service to have improved (MSH/WHO/DAP 1997, Shaw & Ainsworth 1996)

Private insurance

- **Zaire:** Although a national insurance mechanism was not determined to be feasible, several mutual societies in Zaire offer some form of health insurance covering both rural and urban areas. Each of these have different characteristics, and in-depth study of four of them was undertaken to determine their advantages and disadvantages. The insurance plans studied provided some type of basic or essential drugs coverage although some plans covered mostly outpatient services while others covered mostly hospitalizations. Overall, these local insurance mechanisms resulted in improved access and a more reliable source of financing than a system based primarily on user fees (Sarmiento 1995)

Figure 3: Financing through health insurance

In the implementation of user fees, prices are set through a combination of a market approach (willingness to pay) and a cost-based accounting method. There are several types of user charges, among which are:-

- *Cost of therapy* : fixed fee for an episode of illness associated with standard treatment
- *Prescription* : standard fee per drug
- *Multi-level item fee* : different standard fee for different drug levels
- *Variable item fee* : fee differs with drug depending on type or cost.

Most Sub-saharan African countries had some experience with cost recovery and revolving fund in the implementation of user charges.

Donor financing and drug donations : Donor financing includes bilateral and multilateral grants. For some countries, internal financing mechanisms for drugs may prove insufficient, even after reforms, and therefore external funding can prove invaluable to relieving immediate human suffering and can allow countries to develop long-term solutions.

The challenge with all external financing, but particularly when it involves the financing of recurrent costs, is to not allow this to substitute for efforts by countries to develop sustainable financing mechanisms. Transitions from external mechanisms to internal mechanisms need to be incorporated in assistance plans from their conception. But it should be recognized that sustainability may require relatively long-term commitments by donors.

Four core principles of drug donation that should be noted are:-

- Maximum benefit to the recipient
- Respect for wishes and authority of the recipient
- No double standards in quality
- No effective communication between donor and recipient

Voluntary and other local financing : Non-governmental organizations are frequently involved and usually play a significant role. This scheme usually involves local and external donation. One of the countries engaging in this scheme is Tanzania where employer provided health care which are furnished through contracts with private care providers or through insurance and reimbursement. Other than that, there is also a sick fund which will pay for the cost of health services for the poorest.

Development loans: Development loans through the World Bank and regional development banks may contribute to long-term development of the human and physical infrastructure for the health sector. However, loans generally should not be used for financing of the cost of drug supplies, as these represent recurrent expenses. There can exist certain exceptions to which may justify the use of loans for procurement (e.g. seeding of revolving drug funds).

As with donor financing, conditions associated with development loans should not distort national drug policies defined by governments.

During the period 1989-1995, the World Bank contributed a pharmaceutical lending which amounted to USD 1,311 million. Countries usually pay from their own resources and interest set in this funding scheme.

Affordability and efficiency

The appropriate choice and use of drugs is the key to the achievement of pharmaceutical policy objectives and should lead to a greater economic efficiency in the health sector. A variety of cost-control measures have been applied at various levels within public and private drug supply systems. The appropriateness of different measures varies with particular health system in each country.

Affordability of drugs for consumers is a public health concern. Private expenditures for pharmaceuticals in developing countries typically account for 50 to 90% of all spending on drugs. Even for rural populations and the urban poor, the most common source of drugs is direct out-of-pocket purchase from the private market.

Use of generic drugs and price controls are the two most commonly pursued mechanisms to promote affordability. Generic competition with price information is effective in this regard. But generic drug markets have grown very slowly in most countries. The strength of public policy commitment to generic drugs is a major determinant of the growth of generic markets. Four essential factors for success appear to be supportive legislation and regulation, reliable quality assurance, professional and public acceptance, and economic incentives.

Various mechanisms exist to control producer prices and distribution margins. Wholesale and dispensing margins based on cost plus a fixed professional fee provide a better incentive for rational dispensing than margins based only on a percentage. The effects of pharmaceutical price controls have been mixed. Paradoxically, a number of developing countries are relaxing price controls on drugs, while governments in industrialized countries are becoming increasingly concerned with pharmaceutical prices. With or without price controls, price transparency should be a central objective.

The main strategies in order to attain affordability and efficiency are:-

- Therapeutic efficiency in drug selection and use
- Cost control measures
 - Bulk purchasing
 - Capping of expenditure/drug selection
 - Marketing and advertisement restrictions
 - Prescribing controls or incentives

- Price control
- Promotion of rational use
- Use of generic products
- User fee and co-payments
- **Affordability for consumers**
 - Large number of competitors, none of which possesses a dominant market share
 - Homogeneity of products
 - Perfect mobility of resources and low barrier to entry
 - Widespread availability of information
- Generic drug strategy**
 - Supportive legislation and regulation
 - Reliable quality assurance capacity
 - Professional and public acceptance
 - Economic incentives

Organizational reforms

Reforms to financing systems cannot be made without organizational reforms that should match the structure of the public and private sectors to their responsibilities in fulfilling policy objectives. Changes may include incorporation of competitive mechanisms within the public sector, decentralization of health service provision, and a greater role for nongovernmental organizations (NGOs) and other non-commercial "third sector" entities.

Competitive mechanisms in public drug supply: Alternative drug supply strategies for public drug supply include the traditional central medical stores system, autonomous supply agencies, the direct delivery system, the prime vendor system, and fully private supply. Several of these systems involve different public-private roles and rely on greater competition to improve efficiency.

The practical results of different mechanisms for public drug supply have yet to be clearly documented. Governments seeking to improve efficiency in public drug supply should do so with the knowledge that a number of options exist and that success depends not only on choosing an appropriate option, but also on the way in which the option is implemented.

Decentralization and integration in drug supply systems: Control and decision-making in health systems is increasingly being decentralized. For drugs, decentralization may improve quantification of drug requirements, inventory control, prescribing, and dispensing. But some degree of centralization may still be required for functions such as drug registration, development of essential drugs lists and standard treatments, quality assurance, and bulk tendering.

Efforts are also being made in some countries to integrate supply systems for family planning, tuberculosis control, and other "vertical" programs into essential drugs programs. Resource-intensive functions such as procurement, quality assurance,

storage and physical distribution may be integrated under the essential drugs program, while financing, quantification of needs, and monitoring may remain under the management of the national control program.

Role of the "third sector": Public and private roles in the pharmaceutical sector should not ignore the vital role of the "third sector." This includes NGOs' health services, not-for-profit essential drugs supply agencies, professional associations, consumer groups, and specialized NGOs such as some national pharmacological organizations.

Recently some governments have explored ways of carrying out "public" functions such as standard-setting or quality control testing through innovative arrangements with third sector institutions. Some of the "third sector organizations that can be involved are service delivery organizations, consumer organizations, professional associations, standard-setting organizations and universities. The various roles played by the third sector should be clearly acknowledged by policy-makers, and ways to best support and involve the sector should be explored.

Health reform in maternal and child health services

Health reform in the maternal and child health services involved both financing and organizational reforms. Among activities involved in this reform are immunization, safe motherhood, tax relief for vaccines, oral rehydration salt (ORS), and contraceptives supply.

Immunization: Routine immunization programs are quite cheap per dose of vaccine. The introduction of vaccine of new vaccines such as Hepatitis B, Haemophilus influenzae Type B (HiB), and the new rotavirus vaccines has also been delayed in many countries, partly because of their high costs. The unknown additional costs include: cold chain, service delivery costs and social mobilization (information, education, communication).

A survey carried out in 78 countries, indicated that three quarter of the countries have their immunization programs or vaccine line items in their national budgets. Most of the governments pay personnel costs and are paying more and more of their vaccine costs, however, few countries pay all non-personnel costs of their immunization programs (DeRoeck et al 1999, Lieghton 1999). Countries like Panama, Nicaragua, and Honduras, which pay for all or nearly all their vaccine costs, still rely on donors to cover between 16% and 39% of their total recurrent non-personnel costs.

Safe motherhood : Motherhood related afflictions are the biggest cause of morbidity and mortality among women between the ages of 15 and 44 (reproductive age group) in developing countries. Of the 585,000 women who die worldwide from

complications of pregnancy and childbirth each year, 99% live in developing countries. Another 15 million women have chronic health problems after childbirth, and 64 million women suffer dangerous complications from pregnancy. In order to improve this situation, promotion on increased use of maternal health services, including safe pregnancy, care of newborns, women's nutrition, family planning and other key reproductive health interventions have been introduced (Lieghton 1999). This initiative is known as the safe motherhood initiative.

Activities under this initiative include gathering information about costs, financing and effectiveness of maternal health services to help decision makers design and implement more efficient and better quality maternal reproductive health services. The reform agenda are to identify and remove financial, management and policy barriers to effective financing, delivery and use of maternal and reproductive health services, and improving clinical knowledge and quality of care. Focus of activities are removing barriers to providing and using of services, costing services to improve value, finding financing alternatives and building local policy capacity (PHR Maternal & Reproductive Health Initiative 1998)

Tax relief for vaccines ORS and contraceptive supplies: A number of developing countries use tax relief for three public health commodities – vaccines, oral rehydration salts (ORS), and contraceptives. Tax relief can take the form of exemptions, waivers, reductions or some contributions. The ultimate goal of using tax relief is to improve the health status of population by increasing the use of public health commodities and associated services (Lieghton 1999).

A global E-mail survey was carried out in late 1997 to see whether countries granted tax exemption for these three commodities. Of the 44 countries queried 22 countries responded: Bolivia, Brazil, Cambodia, Djibouti, Dominican Republic, Eritrea, Ghana, Guatemala, Indonesia, Jordan, Kenya, Madagascar, Malawi, Morocco, Mozambique, Nicaragua, Philippines, Senegal, Tanzania, Uganda, Zambia and Zimbabwe. Of the 22 respondents, 15 (68%) grant some form of tax relief (Krasovec & Connor 1998).

Health reform in South Africa and Zambia

In both South Africa and Zambia, health care financing changes occurred within the broader programs of health system reform that were introduced during the 1990s to improve equity and efficiency of health care delivery. Table 5 outlines the health care financing reforms that were considered in each country as well as the parallel, institutional reforms that were implemented (Gilson et al 2000).

Impacts of policy change were influenced by the extent to which financing reforms were linked to one another. In Zambia for example, there were weak links between individual resource mobilization policies: cost sharing policies were implemented without establishing an effective exemption mechanism for the indigent, and a mismatch between prepayment premium levels and existing fee levels created perverse incentives for bypassing primary care facilities. In South Africa, the benefits of free care policies on utilization and equity were compromised by slow moving implementation of policies supporting primary health care. Geographic barriers continued to limit the improvements in access resulting from the removal of financial barriers. On the other hand organizational reforms play a critical role in strengthening capacity to implement financing policy changes and vice versa.

Health reform in Malaysia

In Malaysia, health reform have been one of the on going continuous process. Various reform activities have taken place in order to improve equity, efficiency accessibility and appropriateness of care namely in the public health sector. Some of the reform activities include the following:-

Family Health

- Maternal and Child Health
 - Safe Motherhood. This project has lead to the introduction of alternative birthing centers at various health clinics to ensure safe delivery
 - Universal child immunization program
 - Breast and cervical cancer screening programs
 - Mental and rehabilitation at primary care level
 - Elderly care programs
 - Adolescent health care programs etc
- Primary Care
 - Family medicine specialists posted in health clinics
 - Alternative medicines
 - New types of facilities providing wider scope of care and building up of paperless clinics and hospitals etc
- Nutrition
 - Food basket program for children aged 6 years old and below and who are underweight from hard core poor families
 - Baby Friendly Hospital Initiatives
 - Code of ethics of infant formula to support the breastfeeding initiative
 - Micronutrient deficiencies
 - Nutrition resource center etc

Food Quality Control

- Food safety
- Food enforcement etc

Disease Control

- Management of emerging of newly infectious diseases
- Remerging of old diseases such as tuberculosis
- Establishment of Public Health laboratory
- Management of non communicable diseases etc.

Health Promotion

- Healthy lifestyle campaign

National Health Management Institute

Quality Programs

- Quality assurance program
- Quality control
- Quality Control circle
- MS ISO 9000
- Innovations in health
- Health technology assessment etc

Health Financing

- Purchasing of services
- Corporatization and privatization

- Health insurance etc

Health Planning and Development

- Upgrading of health care facilities
- Existence of more private health care facilities
- Upgrading of skills of health personnel
- Review of fees act
- Introduction of specialized services etc

Since its independence, Malaysia have undergone various levels of reform in order to improve the health of the nation. More newer activities are being studied in line with the current and future requirements.

ISSUES

There are various issues that need to be looked into and addressed in making decisions with regards to health reform. Among the issues are as follows:-

- Balancing the interest of various population, income, commercial values, and health provider groups
- Financial sustainability
- Cost effectiveness allocation of public health resources and financing alternatives for the public sector services conflict with or compromise their traditional equity goals
- Faces of equity in health sector

Table 5: Reforms of focus in South Africa and Zambia

Type of reforms	Specific reforms	
	South Africa (1994-1999)	Zambia (1991-1999)
Resource Mobilization	<ul style="list-style-type: none"> • Removal of user fees for pregnant and nursing women and children under six and for primary care. • Restructuring of public hospital fees • Development of proposals for social health insurance 	<ul style="list-style-type: none"> • Introduction/expansion of user fees • Development of exemption policy • Introduction of prepayment scheme
Resource allocation	<ul style="list-style-type: none"> • Development and implementation of inter-provincial resource allocation formulae • Budget reform to reallocate resources between levels of care 	<ul style="list-style-type: none"> • Development and implementation of inter-district resources allocation formulae • Budgetary decentralization to district and hospital boards • Budget reform throughout government leading to global budget for provinces.
Parallel, Institutional reforms	<ul style="list-style-type: none"> • Creation of provinces within a semi-federal state • Proposals to strengthen public hospital management • Development of district health system 	<ul style="list-style-type: none"> • Creation of the Central Board of Health (CBOH) as implementation arm of the Ministry of Health. • Increased autonomy to public referral hospitals and the establishment of hospital boards • Strengthening of the district health system with formal autonomous boards

CONCLUSION

There are various options that can be chosen to improve health services delivery. One must bear in mind that one needs to sacrifice something in order to obtain another. It is important to be able to balance the necessity and actual requirements, and get the optimum benefit from any health reform activities carried out.

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